

		FOR OFF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0018424</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Children's Habilitation Center</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1-1-05</u> to <u>12-31-05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																							
Address: <u>121 West 154th Street</u> <u>Harvey</u> <u>60426</u>																									
<div>NumberCityZip Code</div>																									
County: <u>Cook</u>																									
Telephone Number: <u>708 596 2220</u> Fax # <u>708 596 2258</u>																									
IDPA ID Number: <u>36-2733740001</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>David Markle</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Executive Director</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td colspan="2"></td><td colspan="2">(Telephone) (_____) Fax # (_____) <div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>David Markle</u>		Paid Preparer	(Title) <u>Executive Director</u>		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____				(Telephone) (_____) Fax # (_____) <div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>					
Officer or Administrator of Provider	(Signed) _____				(Date) _____																				
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Paid Preparer	(Title) <u>Executive Director</u>																								
	(Signed) _____			(Date) _____																					
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
		(Telephone) (_____) Fax # (_____) <div>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div>																							
Date of Initial License for Current Owners: <u>02-05-73</u>																									
Type of Ownership:																									
<table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																							
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	<input type="checkbox"/> Limited Liability Co.																								
	<input type="checkbox"/> Trust																								
	<input type="checkbox"/> Other _____																								
In the event there are further questions about this report, please contact: Name: <u>Beverly Hubbard</u> Telephone Number: <u>708 596 2220</u>																									

#	0018424	Report Period Beginning:	1-1-05	Ending:	12-31-05
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D. How many bed-hold days during this year were paid by the Department?

655 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
 YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started **2-5-73**

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☐ **NO** ☒ **If YES, enter number**
of beds certified _____ **and days of care provided** _____

Medicare Intermediary

ACCRUAL	<input checked="" type="checkbox"/>	MODIFIED CASH*	<input type="checkbox"/>	CASH*	<input type="checkbox"/>
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12-31-05 **Fiscal Year:** 12-31-05
*** All facilities other than governmental must report on the accrual basis.**

* All facilities other than governmental must report on the accrual basis.

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Children's Habilitation Center # 0018424 Report Period Beginning: 1-1-05 Ending: 12-31-05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	65,859			65,859		65,859		65,859			1
2	Food Purchase		127,137		127,137		127,137		127,137			2
3	Housekeeping	144,796	19,729	100,460	264,985		264,985		264,985			3
4	Laundry	46,098	2,957		49,055		49,055		49,055			4
5	Heat and Other Utilities			80,698	80,698		80,698		80,698			5
6	Maintenance	79,355	18,547		97,902	9,796	107,698		107,698			6
7	Other (specify):*			21,483	21,483	(1,152)	20,331		20,331			7
8	TOTAL General Services	336,108	168,370	202,641	707,119	8,644	715,763		715,763			8
	B. Health Care and Programs											
9	Medical Director	64,298			64,298		64,298		64,298			9
10	Nursing and Medical Records	2,336,927	454,042	454,301	3,245,270	(86,383)	3,158,887		3,158,887			10
10a	Therapy	874,553	263,964		1,138,517		1,138,517		1,138,517			10a
11	Activities	80,530	1,687		82,217		82,217		82,217			11
12	Social Services	63,710			63,710	40,317	104,027		104,027			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Activity Bus			165	165	(165)						15
16	TOTAL Health Care and Programs	3,420,018	719,693	454,466	4,594,177	(46,231)	4,547,946		4,547,946			16
	C. General Administration											
17	Administrative	212,833			212,833		212,833		212,833			17
18	Directors Fees											18
19	Professional Services			59,545	59,545	(22,338)	37,207		37,207			19
20	Dues, Fees, Subscriptions & Promotions			7,358	7,358		7,358	(1,784)	5,574			20
21	Clerical & General Office Expenses	195,919	16,179	17,527	229,625		229,625		229,625			21
22	Employee Benefits & Payroll Taxes			664,786	664,786		664,786		664,786			22
23	Inservice Training & Education			17,551	17,551		17,551		17,551			23
24	Travel and Seminar			13,765	13,765		13,765	(13,765)				24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			58,074	58,074		58,074		58,074			26
27	Other (specify):* See schedule			10,235	10,235	(1,107)	9,128	(7,002)	2,126			27
28	TOTAL General Administration	408,752	16,179	848,841	1,273,772	(23,445)	1,250,327	(22,551)	1,227,776			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,164,878	904,242	1,505,948	6,575,068	(61,032)	6,514,036	(22,551)	6,491,485			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Children's Habilitation Center #0018424 Report Period Beginning: 1-1-05 Ending: 12-31-05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			48,372	48,372		48,372	(12,432)	35,940			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			130,095	130,095		130,095		130,095			33
34	Rent-Facility & Grounds					10,094	10,094		10,094			34
35	Rent-Equipment & Vehicles					165	165		165			35
36	Other (specify):* Replacement Tax			2,000	2,000		2,000	(2,000)				36
37	TOTAL Ownership			180,467	180,467	10,259	190,726	(14,432)	176,294			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					50,773	50,773		50,773			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			421,387	421,387		421,387		421,387			42
43	Other (specify):* Teachers Salaries	118,450			118,450		118,450		118,450			43
44	TOTAL Special Cost Centers	118,450		421,387	539,837	50,773	590,610		590,610			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,283,328	904,242	2,107,802	7,295,372		7,295,372	(36,983)	7,258,389			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,432)			9
10	Interest and Other Investment Income	(5,704)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,298)			13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(13,765)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,784)			25
26	Income Taxes and Illinois Personal Property Replacement Tax	(2,000)			26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Medical Prof</u>				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,983)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (36,983)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	<u>Gift and Coffee Shops</u>					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	<u>Other-Attach Schedule</u>					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9	Non-Straight-Line Depreciation	(12,432)	30
10	Interest and Other Investment Income	(5,704)	30
11			11
12			12
13	Sales Tax	(1,298)	13
14			14
15			15
16			16
17			17
18			18
19	Entertainment & Meals	(13,765)	19
20			20
21			21
22			22
23			23
24			24
25	Fund Raising, Advertising and Promotional	(1,784)	25
26	Replacement Tax	(2,000)	26
27			27
28			28
29	Medical Professionals	(36,717)	29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(73,700)	49

Summary A

12-31-05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Children's Habilitation Center # 0018424 Report Period Beginning: 1-1-05 Ending: 12-31-05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Markle	Executive Director	Administration	32.34		40	100.00	Wages	\$ 128,697	17/1	1
2	Lowell Zollar	Medical Director	Medical Director	20.54		20	50.00	Wages	64,298	9/1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 192,995		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Children's Habilitation Center # 0018424 Report Period Beginning: 1-1-05 Ending: 12-31-05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
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	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	N/A						\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	N/A												6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	N/A												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000128,5278

2001147,5309

2002128,13410

2003130,60611

2004133,49012

FOR OHF USE ONLY

13FROM R. E. TAX STATEMENT FOR 2004\$13

14PLUS APPEAL COST FROM LINE 5\$14

15LESS REFUND FROM LINE 6\$15

16AMOUNT TO USE FOR RATE CALCULATION \$16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Children's Habilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0018424

CONTACT PERSON REGARDING THIS REPORT Beverly Hubbard

TELEPHONE (708)595-2220 FAX #: (708)596-2258

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 29-18-217-045-0000	121 W 154th Street	\$ 131,434.70	\$ 131,434.70
2. 29-18-217-046-0000	121 W 154th Street	\$ 1,950.92	\$ 1,950.92
3. 29-18-217-044-0000	121 W 154th Street	\$ 104.36	\$ 104.36
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 133,489.98	\$ 133,489.98

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

20,000

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

N/A

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility Location	46,186	1971	\$ 58,845	1
2					2
3	TOTALS	46,186		\$ 58,845	3

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	70		1973	1973	\$ 828,774	\$	35	\$	\$	\$ 828,774	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Improvements			1983	12,961		15			12,961	9	
10	Improvements			1984	19,492		18			19,492	10	
11	Improvements			1985	17,877		19			17,877	11	
12	Improvements			1986	27,432		19			27,432	12	
13	Additions			1988	4,961	157	31.5		(157)	4,961	13	
14	Additions			1989	39,620	1,258	31.5		(1,258)	39,620	14	
15	Additions			1990	87,762	2,786	31.5		(2,786)	87,762	15	
16	Additions			1991	3,429	109	31.5		(109)	3,429	16	
17	Additions			1993	26,119	829	31.5	828	(1)	10,771	17	
18	Additions			1994	20,166	517	39	511	(6)	6,175	18	
19	95 Generator			1995	16,007	410	39	400	(11)	4,462	19	
20	Gas Line			1995	2,500	64	39	63	(1)	698	20	
21	Oxygen Air			1995	121,201	3,108	39	3,112	4	31,096	21	
22	Electrical			1995	17,568	450	39	438	(13)	4,891	22	
23	Walk Ramp			1995	1,100	28	39	28	(1)	307	23	
24	Air Handler Heat			1995	696	18	39	17	(0)	194	24	
25	Electrical System			1996	2,250	58	39	57	(0)	576	25	
26	Electrical System			1996	5,925	152	39	148	(3)	1,502	26	
27	Counter Tops			1997	1,264	32	39	32	(0)	291	27	
28	Oxygen Air System			1997	17,969	461	39	460	(1)	4,144	28	
29	Roofing			1997	1,520	39	39	38	(1)	347	29	
30	Smoke Detector			1998	1,350	35	39	35	(0)	277	30	
31	Nurse Station			1998	2,739	70	39	70	(0)	559	31	
32	Nurse Station			1998	2,739	70	39	70	(0)	559	32	
33	Building Wiring			1999	5,438	139	39	138	(1)	971	33	
34	Gravel & Car Bumper			2000	1,399	36	39	35	(1)	213	34	
35	Install Wiremold & New Electrical Outlets			2001	9,450	242	39	242	0	1,020	35	
36											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Fire Dampers	2002	\$2,000	\$51	39	\$51	\$	\$199	37
38	Headwalls for Oxygen	2003	55,216	1,416	39	1,416		3,009	38
39	Medical Air Piping	2003	16,000	410	39	410		838	39
40	Windows	2005	2,552	33	39	30	(3)	30	40
41	Compressor	2005	2,290	55	7	327	272	327	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,377,767	\$13,034		\$8,957	\$(4,077)	\$1,115,762	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 177,209	\$ 34,493	\$ 25,680	\$ (8,813)		\$ 144,006	71
72	Current Year Purchases	6,519	845	1,304	459		1,304	72
73	Fully Depreciated Assets	529,568					529,568	73
74								74
75	TOTALS	\$ 713,296	\$ 35,338	\$ 26,984	\$ (8,354)		\$ 674,878	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,149,908	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,372	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,941	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,431)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,790,640	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐YES☐NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES ☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 745,006	\$	1
2	Cash-Patient Deposits	53,063		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,500)	1,612,437		3
4	Supply Inventory (priced at)	7,020		4
5	Short-Term Investments	473,817		5
6	Prepaid Insurance	14,021		6
7	Other Prepaid Expenses	2,238		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,907,602	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	58,845		13
14	Buildings, at Historical Cost	1,377,768		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	713,296		16
17	Accumulated Depreciation (book methods)	(1,614,624)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 535,285	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,442,887	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 77,983	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	53,063		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	421,669		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,008		31
32	Accrued Real Estate Taxes(Sch.IX-B)	146,839		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 701,562	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 701,562	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,741,325	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,442,887	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,156,072	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,156,072	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,538	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(515,285)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (414,747)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,741,325	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,713,775	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,713,775	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	170,871	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 170,871	8
	C. Other Operating Revenue		
9	Payments for Education	487,638	9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 487,638	23
	D. Non-Operating Revenue		
24	Contributions	2,340	24
25	Interest and Other Investment Income***	21,287	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,627	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,395,911	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	707,119	31
32	Health Care	4,675,910	32
33	General Administration	1,310,489	33
	B. Capital Expense		
34	Ownership	180,467	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	421,387	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,295,372	40
41	Income before Income Taxes (line 30 minus line 40)**	100,539	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 100,539	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number	Children's Habilitation Center
--------------------------------------	---------------------------------------

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,880	2,120	\$ 66,865	\$ 31.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,049	15,205	426,477	28.05	3
4	Licensed Practical Nurses	17,342	18,575	410,801	22.12	4
5	CNAs & Orderlies	118,133	130,073	1,348,673	10.37	5
6	CNA Trainees					6
7	Licensed Therapist	27,040	29,830	741,544	24.86	7
8	Rehab/Therapy Aides	7,881	10,169	133,009	13.08	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,788	2,080	63,710	30.63	11
12	Dietician	1,880	2,120	45,220	21.33	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,245	2,214	22,113	9.99	15
16	Dishwashers					16
17	Maintenance Workers	3,999	4,408	79,319	17.99	17
18	Housekeepers	11,490	12,902	134,657	10.44	18
19	Laundry	3,878	4,598	46,012	10.01	19
20	Administrator	2,080	2,080	128,697	61.87	20
21	Assistant Administrator	1,768	2,080	84,136	40.45	21
22	Other Administrative	3,904	4,328	88,852	20.53	22
23	Office Manager	1,928	2,080	35,880	17.25	23
24	Clerical	4,986	5,898	70,353	11.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	1,040	1,040	64,298	61.83	27
28	Qualified MR Prof. (QMRP)	5,240	5,784	93,734	16.21	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	6,519	7,979	80,530	10.09	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Teachers	7,502	8,703	118,450	13.61	33
34	TOTAL (lines 1 - 33)	245,572	274,266	\$ 4,283,330 *	\$ 15.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director				36
37	Medical Records Consultant	32	1,120	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	53	2,935	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	555	17,760	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	72	3,600	12-6	45
46	Other(specify) Psychologist	181	14,480	10-3	46
47	Medical Professionals	245	36,717	19-3	47
48	Ophthalmologist	18	1,460	10-3	48
49	TOTAL (lines 35 - 48)	1,276	\$ 79,872		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,223	\$ 104,033	10/3	50
51	Licensed Practical Nurses	6,745	227,462	10/3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,968	\$ 331,495		53

[illegible]

Facility Name & ID Number Children's Habilitation Center

0018424

Report Period Beginning:

1-1-05

Ending:

12-31-05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Ill Hlth Care Assoc \$4,172
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 36,275 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? _____
If YES, give effective date of lease. No
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 421,387
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Blackman Kallick The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.